Introduction to MEDICARE

A basic orientation
Hospital insurance part A
Medical insurance part B

HEALTH CARE FINANCING ADMINISTRATION
Medicare Bureau

(2-78)

This booklet is designed to summarize title XVIII of the Social Security Act for the specific purpose of training Health Care Financing Administration and Social Security Administration employees.

It does not take the place of regulations, operating prodecures, or manual instructions.

Medicare Bureau
Division of Management
Training and Career Development Branch
Program Training Group

Additional copies of this booklet can be obtained by filling out the order form found at the back of this publication and mailing to: Health Care Financing Administration; Administrative Services Section; 6401 Security Boulevard; Baltimore, Maryland 21235

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Note: The PREMIUM AMOUNTS shown in this booklet are effective on July 1, 1978. If this booklet is used prior to 7-1-78, note that the HI Premium is $54.00 and the SMI premium is $7.70.

What is Medicare?

It's a Federal health insurance program for people age 65 or over and for disabled beneficiaries and persons with chronic renal disorders. The program was established by an act of Congress in 1965.

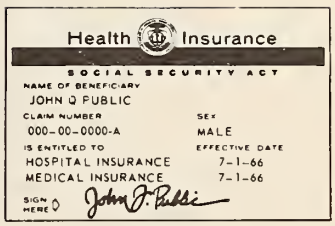
The Medicare program has two parts . . .

1 **Hospital Insurance (Part A)**
This coverage is available to nearly everyone age 65 or over and effective 7/1/73, is also available to disabled beneficiaries and persons with chronic renal disease.

2 **Medical Insurance (Part B)**
This part is voluntary and, though in most cases the beneficiary is automatically enrolled, he may decline coverage if he wishes. Part B enrollment is mandatory for persons who enroll for hospital insurance that requires a monthly premium.

MEDICARE

•HOSPITAL INSURANCE
PART A


Health Insurance
SOCIAL SECURITY ACT
NAME OF BENEFICIARY
JOHN Q PUBLIC
CLAIM NUMBER
000-00-0000-A
SEX
MALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL INSURANCE 7-1-66
MEDICAL INSURANCE 7-1-66
SIGN HERE
John J. Public

•MEDICAL INSURANCE
PART B

Hospital insurance helps pay for medically necessary services which are covered by the program and are provided by health facilities participating in Medicare.

What is a participating facility?

To participate in the Medicare program, health facilities must meet standards which help assure that they will be able to provide high quality health care. In addition, they must not charge the Medicare beneficiary for services paid for by the program, and they must abide by title VI of the Civil Rights Act, which prohibits discrimination based on race, color, or national origin.

Hospital insurance helps pay for services received when a beneficiary is:

- **An inpatient in a hospital**
  and if further care is needed after a hospital stay . . .
- **An inpatient in a skilled nursing facility,**
  or
- **A patient at home receiving services from a Home Health Agency**

The services hospital insurance helps pay for are limited to *Covered Services.*

HOSPITAL INSURANCE

- AN INPATIENT IN A HOSPITAL,
- AN INPATIENT IN A SKILLED NURSING FACILITY, OR
- A PATIENT AT HOME RECEIVING SERVICES FROM A HOME HEALTH AGENCY.

The financing of hospital insurance

The hospital insurance program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected along with regular social security contributions from wages and self-employment income earned during a person's working years.

In addition, uninsured persons desiring coverage, who are not otherwise eligible, pay a monthly premium of $63.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid.

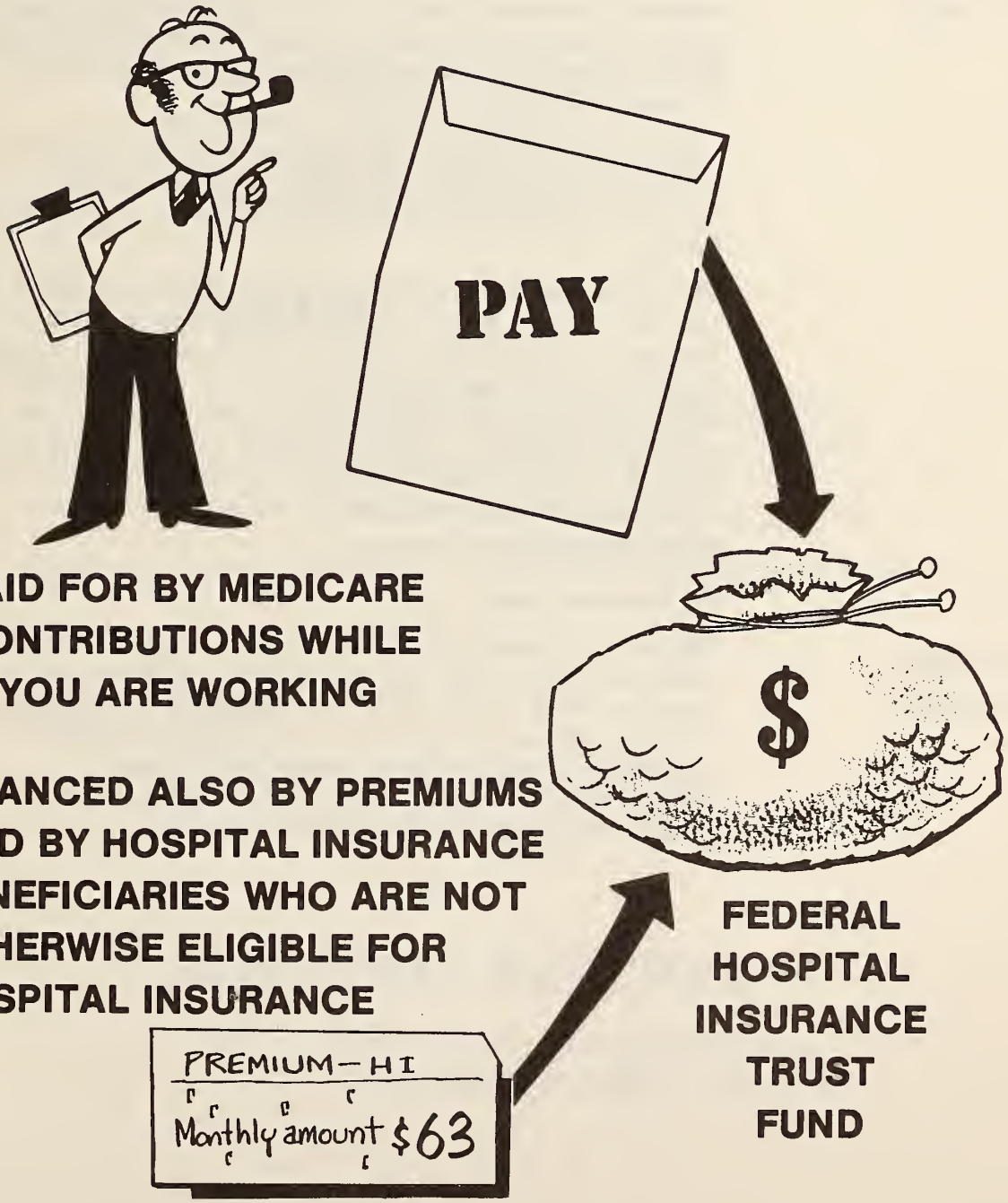
In addition, the law provides that the various dollar amounts for which the beneficiary is responsible be reviewed annually. These dollar amounts include the first $144 of hospital charges in each benefit period and different per-day amounts after certain periods of benefit use in hospitals and skilled nursing facilities. These are described on the following pages. The law also provides that if this annual review shows that hospital costs have changed significantly these amounts must be adjusted for the following year.

How are hospital insurance benefits counted?

When the beneficiary is an inpatient in a hospital up to 90 days are available for each *benefit period.*

- For the first 60 days—hospital insurance pays for all covered services, except for the first $144 (deductible)
- The 61st through the 90th day—hospital insurance pays for all covered services, except for $36 per day (coinsurance)
- Once the beneficiary has taken care of the first $144 of hospital expenses in each *benefit period* he does not have to pay it again, even if he has to go back in a hospital more than once in that same *benefit period.*

How Hospital Insurance Benefits Are Financed



PAID FOR BY MEDICARE CONTRIBUTIONS WHILE YOU ARE WORKING

FINANCED ALSO BY PREMIUMS PAID BY HOSPITAL INSURANCE BENEFICIARIES WHO ARE NOT OTHERWISE ELIGIBLE FOR HOSPITAL INSURANCE

FEDERAL HOSPITAL INSURANCE TRUST FUND

What is a benefit period?

A "benefit period" is simply a period of time measuring the beneficiary's use of hospital insurance benefits.

How does it work?

The beneficiary's *first* benefit period begins with admission to a qualified hospital or skilled nursing facility (after hospital insurance entitlement begins). His first benefit period ends as soon as he has not been an in-patient of any hospital or other facility primarily providing skilled nursing or rehabilitative services *for 60 days in a row.*

After that, the beneficiary can start a *new* benefit period and *renew* his entitlement to full hospital insurance benefits the next time he enters a qualified hospital or skilled nursing facility.

There is no limit to the number of benefit periods a beneficiary may have. There is an easy way to remember the rule. Just keep in mind that any time a beneficiary is not in any hospital or other facility mainly providing skilled nursing care for 60 days in a row, a new benefit period will begin the next time he goes into a qualified hospital or skilled nursing facility. And, of course, for each new benefit period, the beneficiary's full hospital insurance benefits are available again to use as he needs them.

Lifetime reserve?

60 additional days

This is like a "bank account" of extra days to draw from if the beneficiary needs them. He can use them if he ever needs more than 90 days of hospital care in the same benefit period. For each "lifetime reserve" day used, hospital insurance pays for all covered services, except for $72 a day.

BENEFIT PERIOD

•BEGINS:

THE FIRST TIME A BENEFICIARY ENTERS A QUALIFIED HOSPITAL OR SKILLED NURSING FACILITY AFTER HIS HOSPITAL INSURANCE BEGINS

•ENDS:

BENEFICIARY HAS NOT BEEN AN IN-PATIENT OF ANY HOSPITAL OR OTHER FACILITY PRIMARILY PROVIDING SKILLED NURSING OR REHABILITATIVE SERVICES 60 DAYS IN A ROW

•NO LIMIT:

THERE IS NO LIMIT TO THE NUMBER OF BENEFIT PERIODS A BENEFICIARY MAY HAVE

•LIFETIME RESERVE

60 EXTRA DAYS TO DRAW UPON IF THE BENEFICIARY NEEDS THEM

Each lifetime reserve day a beneficiary uses permanently reduces the total he has left.

Many times a beneficiary will want to use his lifetime reserve days if he needs hospital care after he has used all his 90 days in a benefit period. Unless he decides not to use them, the extra days of hospital care that he uses are automatically taken from his lifetime reserve.

A beneficiary does not have to use his lifetime reserve days if he does not wish to do so. In making his decision, he should consider any private insurance he has which may pay for some or all of his additional hospital care. And, of course, the beneficiary may wish to talk to his doctor or the people at the hospital about whether in his particular situation he should draw on his lifetime reserve.

Example–

Mr. Beneficiary had to go to the hospital a number of times in the same benefit period and used up all his 90 days. Before a new benefit period could start, he again needed to go to a hospital. Mr. B. can draw from his "lifetime reserve" days to help him pay for the hospital care.

Note–

The beneficiary doesn't have to bother about trying to keep track of how many "days" or "visits" he uses in each benefit period. The notice he receives from the Social Security Administration after he has used any hospital insurance benefits will tell him how many benefit "days" and "visits" he has left in that benefit period.

Example–

Mr. Beneficiary was in the hospital for 14 days and then went home.

After being at home for 80 days, Mr. B. needs to return to the hospital. When Mr. B. is admitted this time, he is in a new benefit period. That means he is again eligible for up to 90 hospital days because more than 60 days have gone by since he was last in a hospital (or other facility primarily providing skilled nursing or rehabilitative services). The benefit days Mr. B. used the time before do not matter because he is in a new benefit period.

However, because Mr. B. had been in the hospital only 14 days, he still had 76 hospital benefit days left in the original benefit period. If he had to go back to the hospital within 60 days, instead of 80, he could have used any of these remaining days he needed during this second stay.

Are benefits limited in psychiatric hospitals?

For care in a psychiatric hospital, there is a lifetime limit of 190 hospital benefit days. Also, for a beneficiary who is an inpatient in a psychiatric hospital on the day his hospital insurance starts, any days spent in such a hospital during the preceding 150 days are subtracted from the days of inpatient psychiatric hospital services available in his first benefit period.

Hospital benefits

The lists below describe the kinds of benefits that hospital insurance will help pay for when the beneficiary is a bed patient in a hospital and some of the services that it cannot pay for.

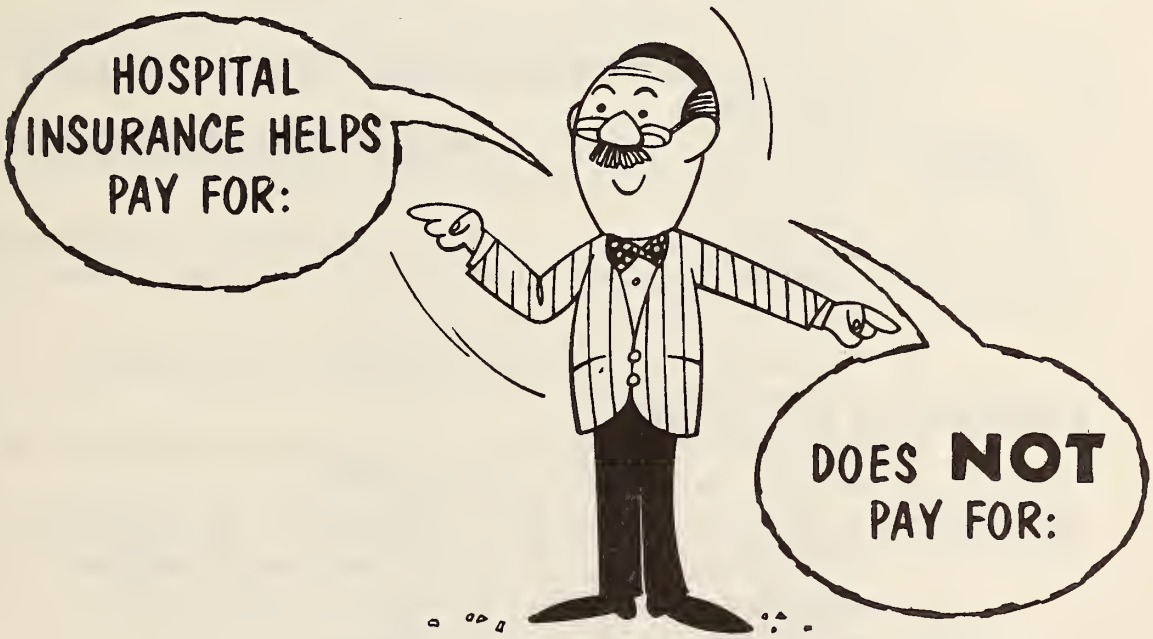
Covered inpatient hospital services

- Semiprivate room (2, 3, 4 beds); private if medically necessary. All meals including special diets.
- Operating room charges.
- Nursing services.
- Drugs furnished by hospital.
- Laboratory tests.
- X-ray and other radiology services.
- Necessary medical supplies.
- Use of appliances and equipment furnished by the hospital such as a wheelchair, crutches, and braces.
- Medical social servcies.

Noncovered inpatient hospital services

- Personal comfort or convenience items furnished at patient's request.
- Private duty nurses.
- Any extra charge for use of a private room, unless it is medically necessary.
- Noncovered levels of care.
- Doctors' services. (Medical insurance helps pay for these.)
- Services not reasonable and necessary for the treatment of an illness or injury.

- DRUGS
- LABORATORY TESTS
- MEDICAL SUPPLIES
- OPERATING ROOM
- NURSING SERVICES
- SEMIPRIVATE ROOM
- MEALS - SPECIAL DIETS
- APPLIANCES & EQUIPMENT
- MEDICAL SOCIAL SERVICE
- X-RAY RADIOLOGY SERVICE



- PRIVATE ROOM
- DOCTORS' SERVICES
- PRIVATE DUTY NURSES
- PERSONAL COMFORT ITEMS
- NONCOVERED LEVELS OF CARE

What are extended care benefits?

Sometimes a patient no longer needs the level of care which hospitals provide, but still needs daily skilled nursing care or other skilled rehabilitation services requiring an inpatient setting. In these cases the doctor may transfer the patient from the hospital to a skilled nursing facility. This is a specially qualified facility which is staffed and equipped to furnish skilled nursing care and many important related health services.

Hospital insurance pays for all covered services in a participating skilled nursing facility for the first 20 days the beneficiary receives such services in each benefit period and all but $18.00 a day for up to 80 more days in that same benefit period if all the following are true:

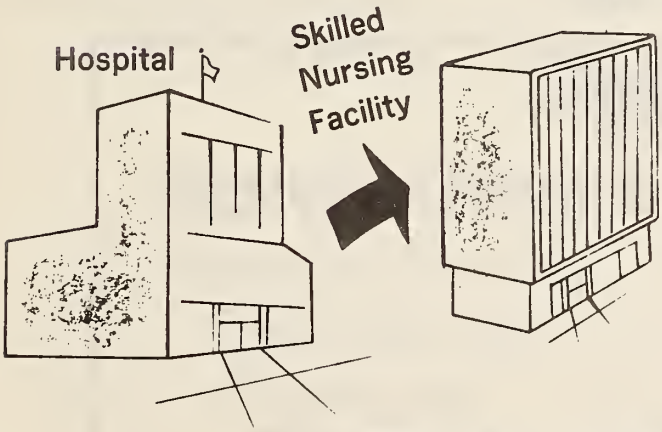
- Patient requires daily skilled nursing care or other skilled rehabilitation services;
- A doctor certifies that the patient needs such care and orders it;
- The care can, as a practical matter only be provided on an inpatient basis in a skilled nursing facility;
- The patient has had a medically necessary stay in a participating (or otherwise qualified) hospital for at least 3 days in a row before his admission;
- The patient is admitted within a limited period, generally 14 days after he leaves the hospital; and
- The patient is admitted for further treatment of a condition for which he was treated in the hospital.

If the patient leaves a skilled nursing facility and is readmitted to one within 14 days, he can continue to use his remaining extended care benefit days for that benefit period without a new 3-day stay in a hospital.

Daily need for skilled nursing care or other skilled rehabilitation services

Doctor certifies patient needs such care

Medically necessary



- 3 day hospital stay
- Transfer requirements met

- Further treatment of a condition treated in the hospital

Extended care benefits

The following list describes some of the kinds of extended care services hospital insurance will help pay for and some of the services that it cannot pay for.

Covered inpatient extended care services

- Semiprivate room (2, 3, 4 beds); private if medically necessary. All meals including special diets.
- Nursing services.
- Drugs furnished by the skilled nursing facility.
- Physical, occupational, and speech therapy.
- Necessary medical supplies.
- Use of appliances and equipment furnished by the facility such as a wheelchair, crutches, and braces.
- Medical social services.

Noncovered inpatient extended care services

- Personal comfort or convenience items furnished at patient's request.
- Private duty nurses.
- Any extra charge for use of a private room, unless it is medically necessary.
- Noncovered levels of care.
- Doctors' services. (Medical insurance helps pay for these.)
- Services not reasonable and necessary for the treatment of an illness or injury.

Extended Care Benefits

NONCOVERED SERVICES

- Personal comfort items
- Private duty nurses
- Private room
- Doctors
- Noncovered levels of care

What are home health benefits?

After the patient has had a qualifying hospital stay (or has received covered extended care services in a participating skilled nursing facility after a qualifying hospital stay), his doctor may decide that the continued care he needs can be best given in his own home through a home health agency. Medicare can pay for this care where all of the following requirements are met:

- He was in a participating (or otherwise qualified) hospital for a medically necessary stay of at least 3 days in a row or received covered extended care services in a participating skilled nursing facility;
- The continuing care he needs includes part-time skilled nursing care or physical or speech therapy;
- He is confined to his home;
- A doctor certifies that the patient is so confined and needs such care and establishes a home health plan for him within 14 days after his discharge from the qualifying hospital or a covered skilled nursing facility stay;
- The home health care is for further treatment of a condition for which the patient received services as a bed patient in the hospital or skilled nursing facility.

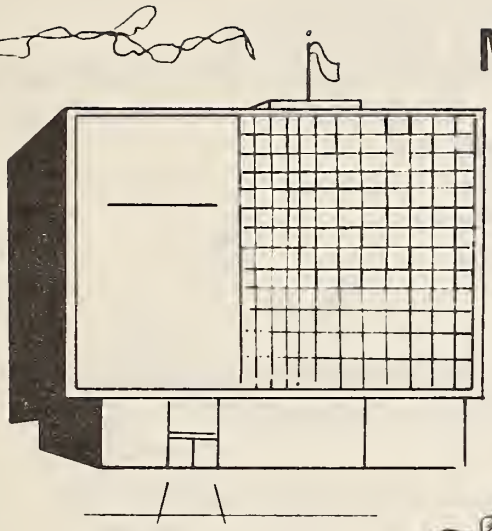
Hospital insurance will pay for as many as 100 home health visits after the start of one benefit period and before the start of another.

The visits must be made to provide a medically necessary covered service and be furnished by a participating home health agency within a year after the patient's most covered skilled nursing facility stay.

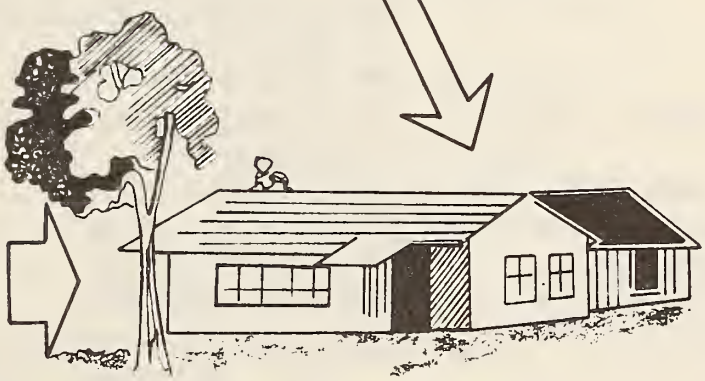
How Are Visits Counted?

One "visit" is counted each time the beneficiary receives a covered health care service from a home health agency. If he receives two different services on the same day (for example, both a nurse and a physical therapist), that would be two visits. It would also be two visits if the beneficiary received the same service twice in a day (such as two calls by a nurse).

MEDICALLY NECESSARY



3 Day hospital stay or covered stay in a participating skilled nursing facility



Confined to home

Doctor establishes plan of treatment within 14 days after discharge

- ***Needs skilled nursing care or physical or speech therapy for treatment of a condition for which the patient received services in the hospital or skilled nursing facility***

Home health benefits

The following list describes the kinds of home health services that hospital insurance will help pay for and some of the services that it cannot pay for.

Covered home health services

- Part-time skilled nursing care
- Physical therapy
- Speech therapy

If you need part-time skilled nursing care, physical therapy, or speech therapy, medicare can also pay for:

- Occupational therapy
- Part-time services of home health aides
- Medical social services
- Medical supplies and equipment provided by the agency

Noncovered home health services

- Full-time nursing care.
- Drugs and biologicals.
- Personal comfort or convenience items.
- Meals delivered to your home.
- Services not reasonable and necessary for the treatment of an illness or injury.

HOSPITAL INSURANCE HELPS PAY FOR:

- PART-TIME SKILLED NURSING CARE
- PHYSICAL THERAPY
- SPEECH THERAPY

  IF YOU NEED PART-TIME SKILLED NURSING CARE, PHYSICAL THERAPY, OR SPEECH THERAPY, MEDICARE CAN ALSO PAY FOR:
  - OCCUPATIONAL THERAPY
  - PART-TIME SERVICES OF HOME HEALTH AIDES
  - MEDICAL SOCIAL SERVICES
  - MEDICAL SUPPLIES AND EQUIPMENT PROVIDED BY THE AGENCY
- INPATIENT HOSPITAL AND SNF SERVICES RECEIVED IN A PARTICIPATING CHRISTIAN SCIENCE SANATORIUM IF IT IS OPERATED, OR LISTED AND CERTIFIED BY, THE FIRST CHURCH OO CHRIST, SCIENTIST, IN BOSTON.

DOES **NOT** PAY FOR:

- FULL TIME NURSING CARE
- DRUGS AND BIOLOGICALS
- COMFORT OR CONVENIENCE ITEMS
- NONCOVERED LEVELS OF CARE
- MEALS DELIVERED TO THE HOME

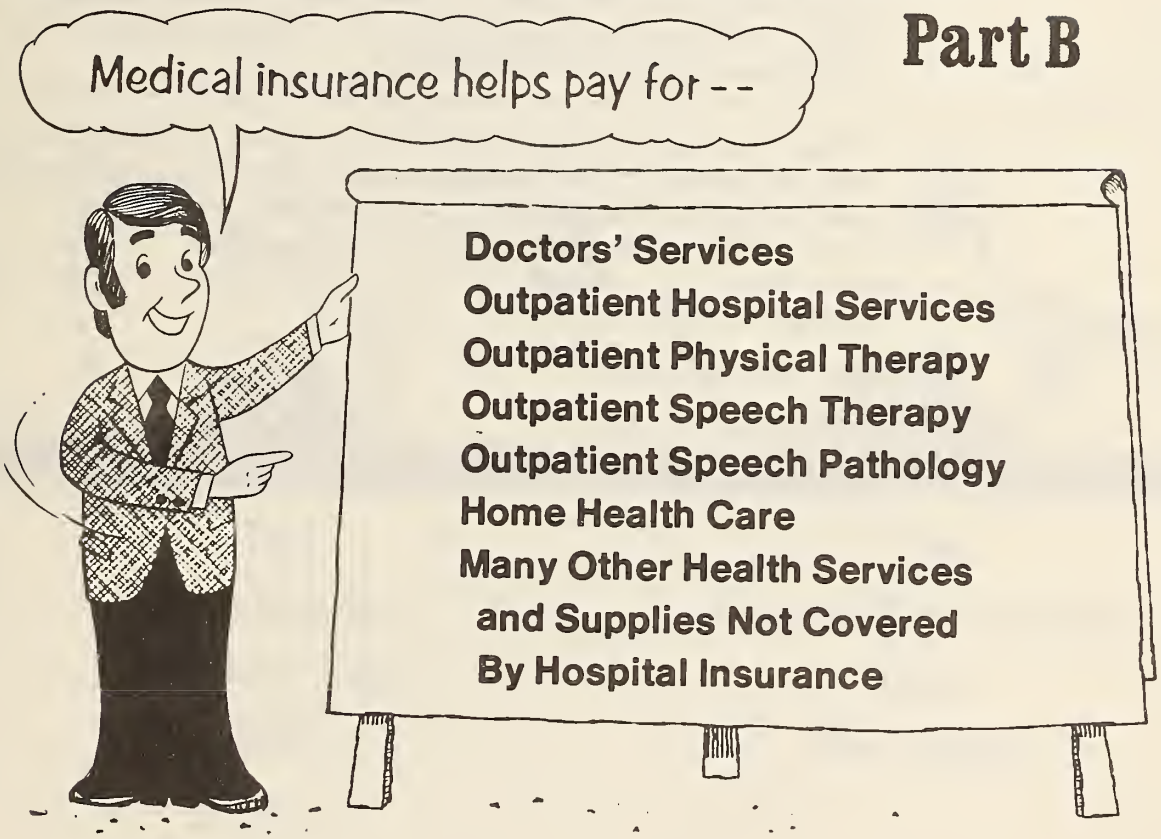
Medical insurance helps pay for doctors' services, outpatient hospital services, outpatient physical therapy and outpatient speech pathology, home health services, and many other health services and supplies not covered by hospital insurance.

Terms to know

- **Covered services:**
  These are the kinds of service medical insurance can help pay for.
- **$60 deductible:**
  For each calendar year, medical insurance does not pay any of the first $60 of reasonable charges for covered services.
- **Reasonable charges:**
  Reasonable charges are determined by the Medicare carriers—the organizations selected in each State by the Health Care Financing Administration to handle medical insurance claims--and take into account the customary charges of the doctor as well as the charges made by other doctors in the locality for similar services.

Medical Insurance

Part B



Who pays for it?

A monthly premium is paid by the beneficiary ($8.20). This premium covers no more than half the cost of medical insurance protection for enrollees over age 65; and amounts to much less than half the cost of protection for younger (disabled) enrollees. The Federal government pays all the other cost.

The premium rate must be reviewed annually. If necessary, the rate is increased in July of each year, but will never increase more than the percentage by which monthly cash benefits have been increased during the past year. Total premiums paid in will meet less than half the cost of the program but the government will pay the difference.

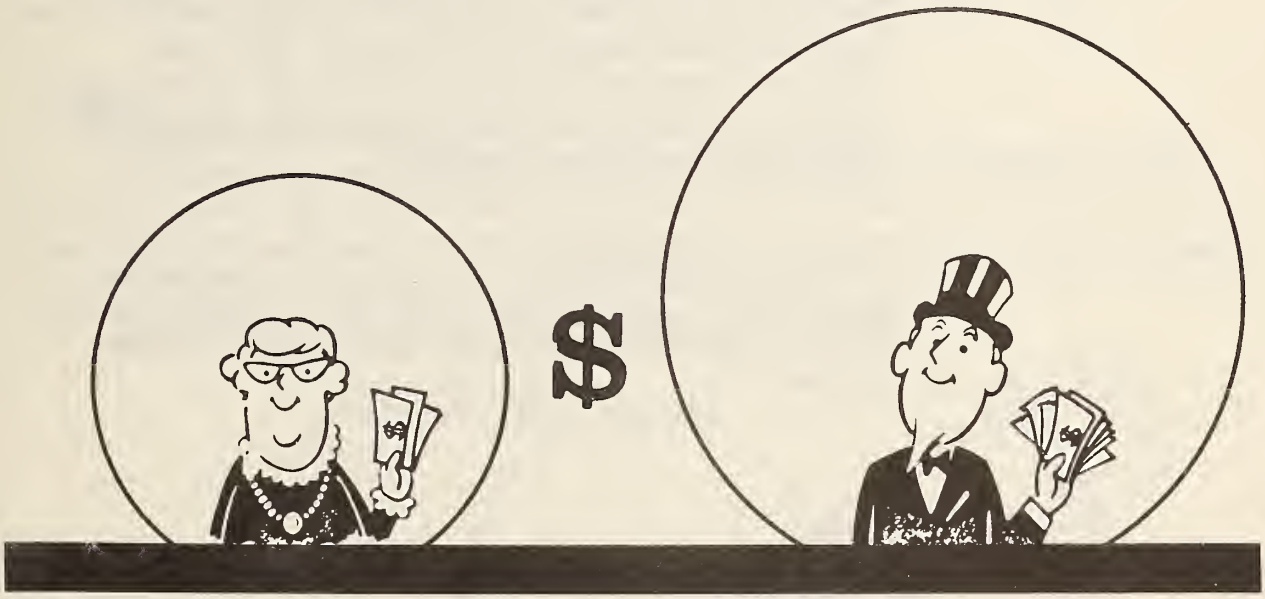
Those who delayed signing up for a long period of time after their first chance or who signed up again after canceling it in the past are required by law to pay an additional 10 percent for each full year they were eligible but not enrolled.

Example–

Eligible but not enrolled:

- one year or longer $9.00
- two years or longer $9.80
- three years or longer $10.70

HOW ARE MEDICAL INSURANCE BENEFITS FINANCED?



The Beneficiaries pay less than half

The Federal Government pays the balance

Payment for covered services

After Medicare records show that the reasonable charges for the beneficiary's bills for covered services are over $60 for a calendar year, medical insurance will pay 80 percent of the reasonable charges in excess of the initial $60 for the rest of that year.

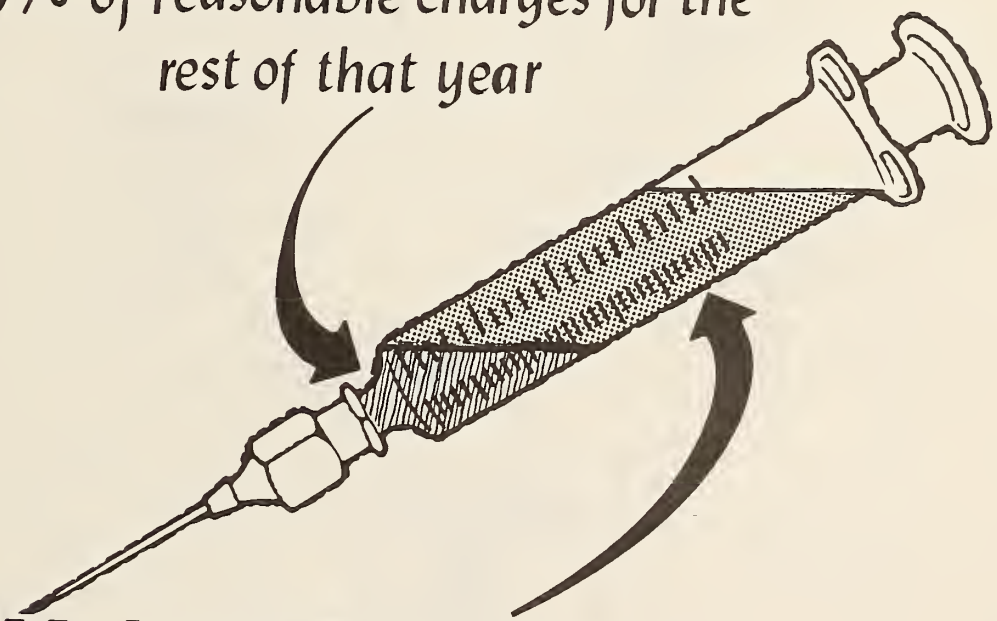
Therefore, the beneficiary is responsible for payment of the first $60 of reasonable charges plus 20 percent of any other reasonable charges for the rest of that year. (However, if the doctor or supplier does not accept assignment, he may charge the beneficiary additional amounts).

Note– There is only *one* $60 medical insurance deductible each year—not a separate $60 deductible for each kind of covered service. Also, medical expenses in the last 3 months of one year can sometimes count toward the $60 deductible for the next year.

WHO PAYS FOR ***COVERED SERVICES*** ?

- **Beneficiary** *pays first $60 of reasonable charges for covered services*

  20% *of reasonable charges for the rest of that year*



- **Medical Insurance**

  Pays **80%** *of reasonable charges for the rest of that year*

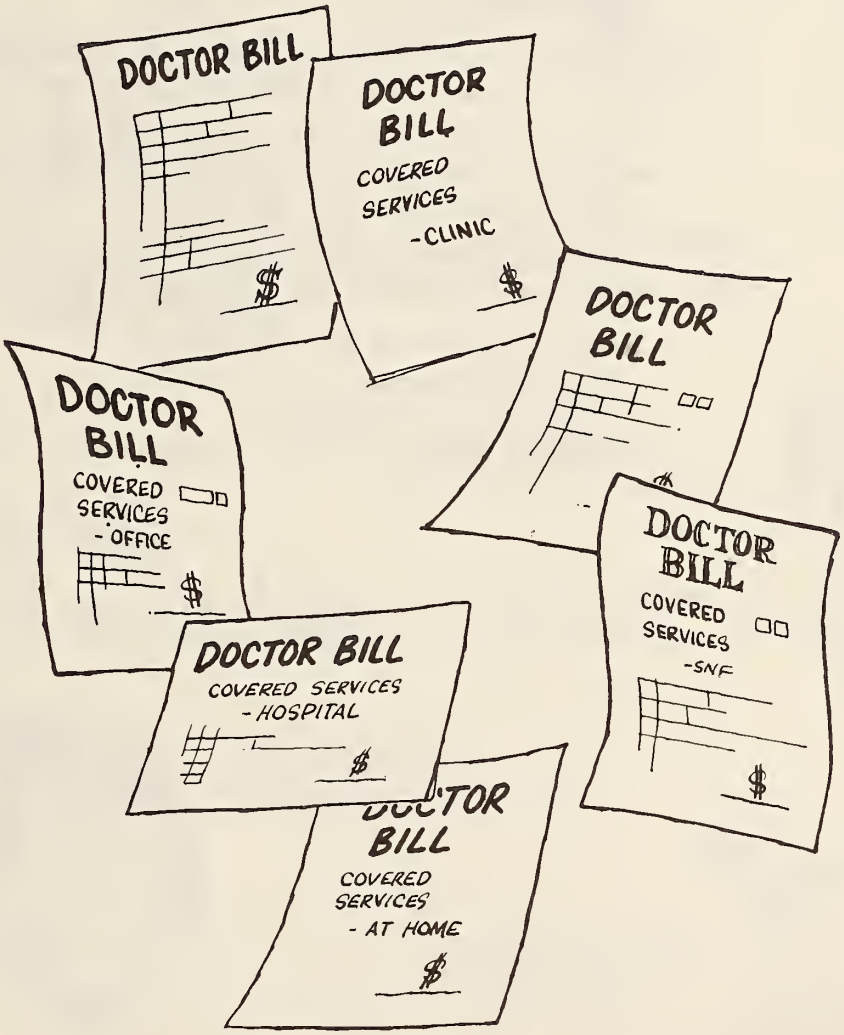
Services rendered by a doctor

Medical insurance will help pay for doctor bills for all *covered services.* The doctor may treat a beneficiary in his office, a hospital, a skilled nursing facility, the beneficiary's home, or at a group practice, health maintenance organization or other clinic.

Payment for covered services received can be made either to the doctor on assignment or to the beneficiary based on an itemized bill (a receipt is not required).

Note– Assignment—the doctor (or supplier) must agree that he will apply for medical insurance payments to be made directly to him. Also, he must agree that his total charge will not exceed the reasonable charge; i.e., that he will not charge the beneficiary more than the deductible and coinsurance for covered services.

MEDICAL INSURANCE WILL HELP PAY FOR DOCTOR BILLS



ALL COVERED SERVICES RECEIVED IN THE U.S.

What doctor services are covered?

- Medical and surgical services by a doctor of medicine or osteopathy.
- Services by a dentist which involves surgery of the jaw or contiguous structures or setting of fractures of the jaw or facial bones.
- Services by a podiatrist which they are legally authorized to perform by the State in which they practice.
- Services of a licensed and qualified chiropractor in treating a subluxation of the spine by manual manipulation if subluxation is demonstrated by x-ray.
- Other services which are ordinarily furnished in the doctor's office and included in his bill such as:
  - Diagnostic tests and procedures
  - Medical Supplies
  - Services of his office nurse
  - Drugs and biologicals which cannot be self-administered.

COVERED SERVICES...

- Medical and surgical services by a doctor of medicine or osteopathy

- Certain services by a doctor of dentistry or dental surgery

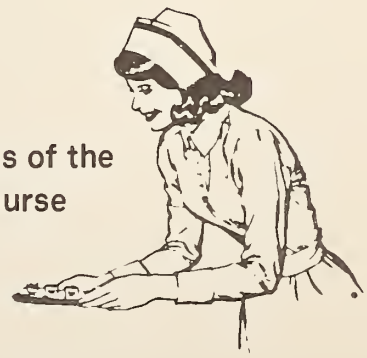
- Legally authorized services of a podiatrist

Other services provided by the doctor-

- Certain services of a chiropractor

- Diagnostic tests and procedures

- Services of the office nurse



- Medical supplies

- Drugs and biologicals which can not be self-administered

What physical therapy services are covered?

Services rendered by a physical therapist in independent practice, who has met the licensing requirements and standards set by regulations are covered under supplementary medical insurance.

- To make these services more accessible, services may be provided in the physical therapists' office, or the beneficiary's residence, under a physician's plan.
- In addition to being subject to the deductible and coinsurance amounts, expenses for these services cannot exceed $80 in a calendar year.

A participating hospital or skilled nursing facility may also provide outpatient physical therapy services to its inpatients.

The requirement for physician certification/recertification for these services must be met.

What speech pathology services are covered?

Speech pathology services furnished to beneficiaries on an outpatient basis by, or under arrangements made by participating hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, clinics, and public health agencies, are covered under supplementary medical insurance.

- The services may be rendered in the participating facility or within the beneficiary's home.
- Although direct physician supervision of these services is not required, the physician must certify that the services were required within the plan of treatment while the individual was under the care of the physician.
- The beneficiary is subject to the regular deductible and coinsurance amounts.

Medical insurance does not pay for . . .

- Routine physical checkups and tests directly related to such checkups.
- Routine and certain other foot care and supportive devices for the feet.
- Eye refractions and examinations for prescribing, fitting, or changing eyeglasses.
- Cosmetic surgery unless it is needed because of accidental injury or to improve the functions of a malformed part of the body
- Routine Dental Care.
- Hearing examinations for prescribing, fitting, or changing hearing aids.
- Immunizations (Unless directly related to an injury or immediate risk of infection such as an anti-tetanus shot given after an injury).
- Services of certain practitioners, for example:

  Christian Science Practitioners.
  Naturopaths.

What services are **NOT** covered by Medical Insurance?

• PART B DOES NOT INCLUDE:

1. ROUTINE PHYSICAL CHECK-UPS, EYE EXAMS, DENTAL CARE
2. ROUTINE FOOT CARE
3. EYEGLASSES - FITTING OR CHANGING
4. HEARING AIDS - FITTING OR CHANGING
5. IMMUNIZATIONS NOT RELATED TO INJURY OR IMMEDIATE RISK OF INFECTION
6. SERVICES OF CERTAIN PRACTITIONERS:

   FOR EXAMPLE...

   - Christian Science Practitioners
   - Naturopaths
7. COSMETIC SURGERY NOT RELATED TO AN ILLNESS OR INJURY

Special attention

► Medical insurance pays (100 percent of) the reasonable charges of radiologists and pathologists for radiology and pathology services received as an inpatient, in a participating or otherwise qualified hospital.

Special rule
Because the full reasonable charges are taken care of when the beneficiary receives laboratory and radiology services as a hospital inpatient his expenses for such services do not count toward the $60 deductible.

► Medical insurance will pay for ambulance transportation by an approved ambulance service to a hospital or a facility offering skilled nursing services only when:

1 the ambulance, its equipment and personnel meet Medicare requirements

2 transportation by other means could endanger the patient's health, and

3 the patient is taken to a facility serving the locality; or the nearest facility that is equipped to take care of him.

Under similar restriction, medical insurance can help pay for ambulance services from one hospital to another, from a hospital to a facility offering skilled nursing services, from a hospital or facility offering skilled nursing services to the patient's home.

RADIOLOGY & PATHOLOGY SERVICES

- 100% of reasonable charges for Radiology and Pathology Services received as an inpatient in a hospital

AMBULANCE SERVICES-

- HOSPITAL
- SKILLED NURSING FACILITY
- HOME

- Medical Insurance will help pay for ambulance service under certain conditions

What are outpatient hospital benefits?

Medicare can pay for covered services received as an outpatient from a participating hospital for the diagnosis or treatment of an illness or injury.

Medical insurance covers 80 percent of the hospital charges after the $60 deductible has been met. The beneficiary is responsible for the remaining 20 percent.

What outpatient services are covered?

- Laboratory services
- X-ray and other radiology services
- Emergency room or outpatient clinic services
- Medical supplies such as splints and casts
- Other diagnostic services
- Drugs and biologicals which cannot be self administered

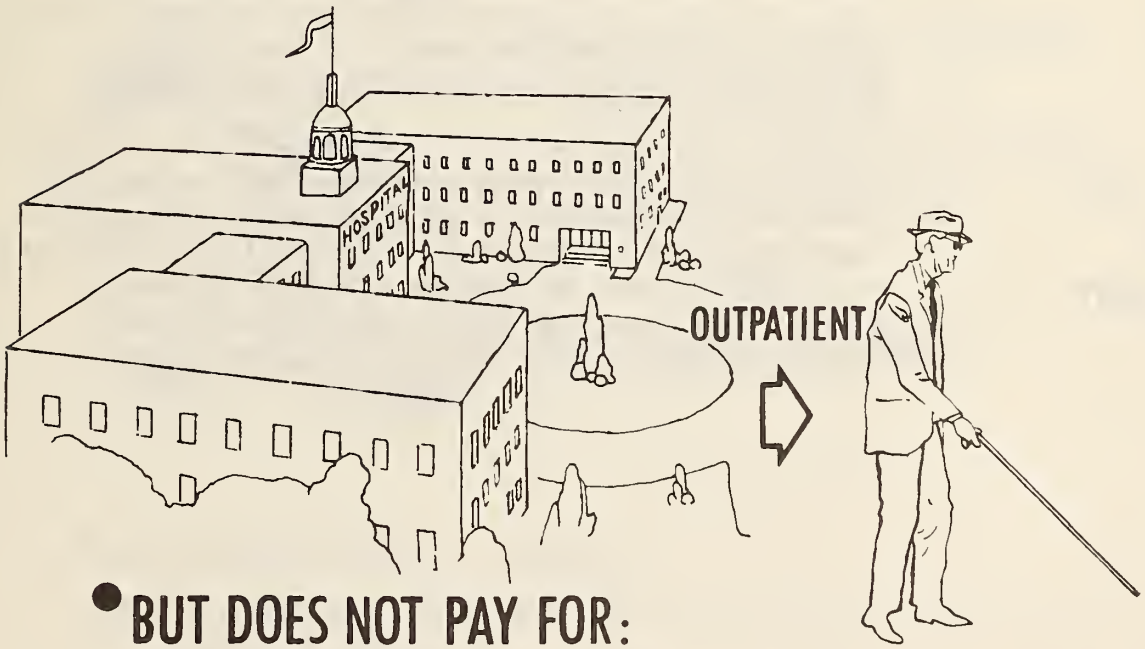
What outpatient services are not covered?

- Routine physical examinations and tests directly related to such examinations
- Eye refractions and examinations for prescribing, fitting, or changing eyeglasses
- Immunizations (unless directly related to an injury or immediate risk of infection such as an anti-tetanus shot given after an injury)
- Hearing examinations for prescribing, fitting, or changing hearing aids
- Routine foot care

OUTPATIENT HOSPITAL BENEFITS

• Medical Insurance Helps Pay For:

- ▶ Laboratory and other diagnostic services
- ▶ X-ray and radiology services
- ▶ Emergency room or outpatient clinic services
- ▶ Medical supplies
- ▶ Other diagnostic services
- ▶ Drugs and biologicals which cannot be self-administered



• BUT DOES NOT PAY FOR:

- ▶ Routine physical examinations and tests directly related to such examinations
- ▶ Eye refractions and examinations
- ▶ Immunizations
- ▶ Examinations for hearing aids
- ▶ Routine foot care

Home health benefits

Medical insurance will help pay for up to 100 home health visits each calendar year, if all the following are true:

- The patient needs part-time skilled nursing care, or physical or speech therapy;
- He must be confined to the home;
- A doctor must certify that he is so confined and in need of such care;
- His doctor must establish and periodically review his plan for home health care; and
- The home health agency must be participating in Medicare.

Note– There is no coinsurance requirement for these benefits. Medicare pays 100% of the reasonable cost after the $60 deductible is met.

How are visits counted?

One "visit" is counted each time the beneficiary receives a covered health care service from a home health agency. If he receives two different services on the same day (for example, both a nurse and a physical therapist) that would be two visits. It would also be two visits if the beneficiary received the same service twice in a day (such as two calls by a nurse).

A DOCTOR DETERMINES THE NEED FOR · · ·

Home Health Care

- A DOCTOR SETS UP AND PERIODICALLY REVIEWS A PLAN FOR HOME HEALTH CARE

if

- THE BENEFICIARY NEEDS PART-TIME SKILLED NURSING CARE OR PHYSICAL OR SPEECH THERAPY

AND IS

- CONFINED TO HOME

- THE HOME HEALTH AGENCY MUST BE PARTICIPATING IN **MEDICARE**

Other medical services and supplies

Medical insurance will help pay for a number of different medical services and supplies which may be necessary in the treatment of an illness or injury. They may be furnished in connection with treatment by the doctor, a medical clinic, or other health facility.

The following list shows the kinds of medical services and supplies that medical insurance can help pay for:

- Diagnostic tests such as X-rays and laboratory tests furnished by approved independent laboratories.
- Radiation therapy.
- Portable diagnostic X-ray services furnished in your home under a doctor's general supervision by an approved supplier of portable X-ray.
- Surgical dressings, splints, casts, and similar devices.
- Rental or purchase of durable medical equipment prescribed by a doctor to be used in your home, e.g., a wheelchair, hospital bed, or oxygen equipment.
- Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation.
- Certain ambulance services.

Note– If a patient is in a hospital or skilled nursing facility and, for some reason, hospital insurance cannot pay for these services (for example, because he has used up his benefit days), medical insurance can help pay for them.

MEDICAL SERVICES AND SUPPLIES

Part B Helps Pay For:

- DIAGNOSTIC TESTS SUCH AS X-RAY AND LABORATORY TESTS
- RADIATION THERAPY
- SURGICAL DRESSINGS, SPLINTS, CASTS, AND SIMILAR DEVICES
- RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT
- DEVICES TO REPLACE ALL OR PART OF AN INTERNAL BODY ORGAN
- CERTAIN AMBULANCE SERVICE

Part B Does Not Pay For:

- PRESCRIPTION DRUGS AND DRUGS THAT CAN BE ADMINISTERED BY THE BENEFICIARY
- HEARING AIDS
- EYEGLASSES
- FALSE TEETH
- ORTHOPEDIC SHOES OR OTHER SUPPORTIVE DEVICES FOR THE FEET

Workshop problems

Workshop problem #1

Mr. Bell began a benefit period on 2/1/78 with a 32 day hospital stay for treatment of a heart attack. He was discharged and sent home to recuperate. He was home 30 days at which time he suffered a second attack and was hospitalized 36 more days before returning home.

1. How many benefit periods are involved here? Why?
2. How many days were used in the first benefit period? How many are left (apart from lifetime reserve days)?
3. Assuming no non-covered expenses such as private room, telephone and television, etc., what is the amount Mr. Bell must pay for his two hospital stays? Why?

Workshop problem #2

Mr. McCoy was admitted to Memorial Hospital on June 1, 1978, for treatment of a gunshot wound. He stayed until August 10, when he was discharged. While he was an inpatient, the charges were as follows:

Semi-private room	$110.00/day
Private duty nurse (3 days only)	$50.00/day
Television (60 days total)	$ 2.50/day

1. How much of the total charges did Mr. McCoy's Hospital Insurance cover? How much must he pay?
2. What is the earliest date Mr. McCoy's benefit period can end?

Workshop problem #3

Beneficiary Laura T. O''Neill was hospitalized on March 14, 1978, and remained in the hospital for 40 days. After a week at home, it became apparent that she needed further care for the treatment of her condition and her doctor admitted her to a SNF. She required and received 30 days of covered care in the SNF and was discharged on the 31st day. The total cost of all covered services for this 30-day stay was $500. How much of this amount is covered by the HI program and how much will Mrs. O'Neill have to pay?

Workshop problem #4

Mrs. Arthur Reed has been enrolled in Medicare from the start, i.e., 7/1/66. She had never been sick until 1978, at which time she broke a hip. Her total expenses at the end of the year were as follows:

1. Physician's expense		
a) in hospital	$250.00	
b) office calls	$150.00	
TOTAL		$400.00
2. Emergency ambulance service from her home to the hospital		$ 50.00
3. Prescription drugs		$ 50.00
4. Purchase of crutches		$ 15.00
TOTAL		$515.00

How much does medical insurance pay out of this total (assuming charges are reasonable)? How much is Mrs. Reed responsible for?

Workshop problem #5

Mrs. Robinson is admitted to the hospital on February 4, 1978, for 10 days of treatment for a kidney condition. This is the first medical care of any kind she has needed since she was covered by the HI and SMI programs. Listed below are the expenses of the illness. Assume that the fees listed for the physician are reasonable charges and that he had agreed to an assignment of benefits. Hospital fees are reasonable costs in this example.

Date	Item	Hospital Fees/ Physician's charge
2/3/78	Physician calls at Mrs. Robinson's home	$ 10
2/4/78	Mrs. Robinson enters hospital	
	semi-private room and board	$ 90/day
	Drugs	$ 60 (total cost)
	Attending physician's services in hospital	$100 (total cost)

How much of the expenses listed above would be paid for by Mrs. Robinson and how much by the HI and SMI programs?

Answer—Workshop problem #1

1. Mr. Bell was home only 30 days before being readmitted with his second attack; therefore, his second stay in the hospital is included in the original benefit period. Mr. Bell's first benefit period ends as soon as he has not been an inpatient in any hospital or other facility primarily providing skilled nursing or rehabilitative services.
2. 68 days. 22 days left.
3. $144 Hospital deductible
   $288 Coinsurance (8 days x $36)
   $432 Total that Mr. Bell must pay.

Answer—Workshop problem #2

1. Hospital Insurance covers $7196
   Mr. McCoy must pay $ 804

   Solution

   a) 6/1/78 - 8/9/78 = 70 days (day of discharge not counted)

   b) 70 × $110/day = $7700

   c) Mr. McCoy must pay the following:

	$144	deductible
	$360	coinsurance (61st - 70th days)
	$504	Total
plus	$150	Private duty nurse ($50 × 3 days)
plus	$150	Television ($2.50 × 60 days)
	$804	

   d) HI covers:

$7700	
less $ 504	(deductible plus coinsurance)
$7196	

   Remember, Hospital Insurance does not pay for private duty nurses or personal comfort or convenience items such as TV.

2. 10/8/78 is the last day of the benefit period, provided he was not an inpatient at a hospital or facility offering skilled nursing services from date of discharge through 10/8/78.

Answer—Workshop problem #3

HI covers $320

Laura O'Neill pays $180

Solution

Of the 30-day stay in the SNF, the first 20 days of coverage is covered in full by Hospital Insurance. The next 10 days were covered by HI except for $18 per day coinsurance which Mrs. O'Neill must pay, i.e., 10 x $18 or $180.

Since the bill for the total 30-day stay was $500, and since she is responsible for $180, HI covers the balance, or $320.

Answer—Workshop problem #4

SMI pays $324
Mrs. Reed pays $191

Solution
Expenses covered by SMI:

1.	$400	Physician expenses
2.	$ 50	Ambulance service
3.	$ 15	Crutches
	$465	TOTAL
less	$ 60	Deductible
	$405	

80% of $405 = $324 (SMI pays)

Mrs. Itus pays $515 less $324, or $191

Mrs. Reed pays:

1.	$50	Prescription drugs
2.	$60	Deductible
3.	$81	Coinsurance
	$191	TOTAL

Remember, prescription drugs are not covered under Part B of the Medicare program.

Answer—Workshop problem #5

1. EXPENSES COVERED BY HI

1 Hospital room & board, 10 days × $90/day	$900.00
2. Drugs	$ 60.00
TOTAL	$960.00

2. EXPENSES COVERED BY SMI

1. Physician's home call	$ 10.00
2. Attending physician's services (in hospital)	$100.00
TOTAL	$110.00

3. Total HI expenses $960.00
   less deductible $144.00

   HI covers $816.00

   Total SMI expenses $110.00
   less deductible $ 60.00

   $ 50.00

   SMI pays 80% of $50.00 or $40.00

4. Mrs. Robinson pays:
   1. $144.00 HI deductible
   2. $ 60.00 SMI deductible
   3. $ 10.00 SMI Coinsurance (20% of SMI expenses after deductible)

   $214.00

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